United States Department of Labor
Employees' Compensation Appeals Board

C.C., Appellant	)	
and	)	**Docket No. 10-1576**
	)	**Issued: February 2, 2011**
U.S. POSTAL SERVICE, PROCESSING & DISTRIBUTION CENTER, Carol Stream, IL, Employer	)	

Appearances:
Appellant, pro se
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 25, 2010 appellant filed a timely appeal from a February 18, 2010 merit decision of the Office of Workers' Compensation Programs. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUE

The issue is whether appellant has more than an eight percent impairment to his right and left arms.

FACTUAL HISTORY

On September 2, 2006 appellant, then a 50-year-old distribution supervisor, filed an occupational claim (Form CA-2) alleging that her bilateral carpal tunnel syndrome was causally related to her federal employment. On December 21, 2006 the Office accepted bilateral carpal tunnel syndrome.

In a report dated February 25, 2009, Dr. Jacob Salomon, a surgeon, noted that appellant had seven OWCP claims. He stated that he would provide an impairment rating for carpal tunnel syndrome. In a report dated March 2, 2009, Dr. Milena Appleby, a neurologist, indicated that a February 26, 2009 electromyogram (EMG) showed no signs of neuropathy or radiculopathy.

By report dated July 21, 2009, Dr. Salomon diagnosed bilateral carpal tunnel syndrome. He provided grip strength results and stated that neurological examination showed decreased pinprick sensation over the median nerve. Dr. Salomon opined that, under Table 15-21 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (sixth edition), appellant had a 17 percent left arm impairment and a 10 percent right arm impairment.

The case was referred to an Office medical adviser for evaluation. In a report dated September 7, 2009, he opined that appellant had no ratable impairment. The Office medical adviser noted that the February 26, 2009 EMG showed no signs of neuropathy or radiculopathy and there was no objective basis for a permanent impairment rating.

By decision dated November 3, 2009, the Office found appellant was not entitled to a schedule award as the medical evidence did not establish permanent impairment related to his accepted conditions.

Appellant requested reconsideration on January 3, 2010. In a report dated October 23, 2009, Dr. Salomon stated that appellant had carpal tunnel syndrome and on examination the left hand and wrist were swollen with decreased grip strength. He also opined that appellant had developed complex regional pain syndrome (CRPS) in the left hand and wrist secondary to carpal tunnel and cervical disc disease. Dr. Salomon indicated that appellant would be referred to a pain management specialist for the CRPS.

In a report dated November 19, 2009, Dr. Anatoly Rozman, a neurologist, provided results of a November 10, 2009 EMG. He reported moderate left median nerve entrapment neuropathy and severe right median nerve entrapment neuropathy.

The Office referred the evidence to an Office medical adviser for evaluation. In a report dated January 27, 2010, the medical adviser identified Table 15-23 of the A.M.A., *Guides*. He opined that, with symptoms of bilateral carpal tunnel syndrome, bilateral positive EMG for carpal tunnel syndrome (CTS) (right worse than left) and bilateral abductor pollicis brevis (APB) muscle atrophy, appellant had eight percent impairment to each arm. The date of maximum medical improvement was March 25, 2008.[1]

By decision dated February 18, 2010, the Office issued schedule awards for eight percent permanent impairment to each arm. The period of the awards covered 49.92 weeks commencing March 25, 2008.

[1] The record contains a March 25, 2008 report from Dr. Martin Lanoff, a physiatrist, who was an Office referral physician pursuant to another claim. He noted that a March 5, 2008 EMG did not show CTS.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act[2] and its implementing regulations[3] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss or loss of use, of scheduled members or functions of the body. However, the Act does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law to all claimants, good administrative practice necessitates the use of a single set of tables so that there may be uniform standards applicable to all claimants.[4] The American Medical Association, *Guides to the Evaluation of Permanent Impairment* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5] For schedule awards after May 1, 2009, the impairment is evaluated under the sixth edition.[6]

ANALYSIS

The Office issued schedule awards for eight percent permanent impairment to each arm. The diagnosis by Dr. Salomon was CTS and under the A.M.A., *Guides* an entrapment/ compression neuropathy is evaluated under Table 15-23.[7] In a July 21, 2009 report, Dr. Salomon had applied Table 15-21, which is for peripheral nerve impairments.[8] The A.M.A., *Guides* specifically state that the peripheral nerve impairment section is not to be used for nerve entrapment.[9] Dr. Salomon did not explain why Table 15-21 would be appropriate in this case and therefore his opinion as to the degree of impairment is of diminished probative value.

The Board notes that in his October 23, 2009 report, Dr. Salomon briefly referred to a diagnosis of complex regional pain syndrome (CRPS) for the left arm. The A.M.A., *Guides* does provide a separate, "stand alone" method for a CRPS impairment that is not to be combined with any other method for the same extremity.[10] The A.M.A., *Guides* note, however, that an accurate diagnosis is difficult and the diagnostic criteria under Table 15-24 must be met, as well as other conditions, before an impairment rating based on CRPS can be made.[11] Dr. Salomon did not

[2] 5 U.S.C. § 8107.

[3] 20 C.F.R. § 10.404.

[4] *See Ronald R. Kraynak*, 53 ECAB 130 (2001); *August M. Buffa*, 12 ECAB 324 (1961).

[5] *Supra* note 3.

[6] FECA Bulletin No. 09-03 (March 15, 2009).

[7] A.M.A., *Guides* 449, Table 15-23.

[8] *Id*. at 436, Table 15-21.

[9] *Id.* at 429.

[10] *Id.* at 452.

[11] *Id.* at 451. The other conditions include that the diagnosis has been present for a year, verified by more than one physician, and other differential diagnoses have been ruled out.

provide a detailed description of the diagnosis[12] or any evidence that would establish a basis for an impairment rating from a CRPS diagnosis.

The Office medical adviser found that under Table 15-23 appellant had an eight percent impairment to each arm. Under this table, a grade modifier is identified based on test findings, physical findings and history. The default upper extremity impairment for grade modifier 3 is eight percent, which is the highest default impairment under the table.[13] The Office medical adviser noted atrophy, symptoms and positive test findings to support his opinion. The default may be modified up or down by one percent based on functional scale, an assessment of impact on daily living activities. Even a severe rating on a functional scale is a grade modifier 3 and would not modify the default value.[14]

The Board finds that the evidence of record does not establish more than an eight percent permanent impairment to each upper extremity. The weight of probative medical opinion is represented by the Office medical adviser. The Board notes that the number of weeks of compensation for a schedule award is determined by the compensation schedule at 5 U.S.C. § 8107(c). For complete loss of use of the arm, the maximum number of weeks of compensation is 312 weeks. Since appellant's impairment totaled eight percent to each arm, she is entitled to eight percent of 312 weeks or 24.96 weeks of compensation for each arm. For both upper extremities, this is a total 49.92 weeks of compensation. It is well established that the period covered by a schedule award commences on the date that the employee reaches maximum medical improvement from residuals of the employment injury.[15] In this case, the Office medical adviser found the date of maximum medical improvement was March 25, 2008, based on the medical evidence of record. No contrary evidence was submitted.

On appeal, appellant submitted an additional medical report. The Board's jurisdiction to review evidence is limited to the evidence that was before the Office at the time of its final decision.[16] For the reasons noted above, the Board finds the evidence of record did not establish more than an eight percent bilateral arm impairment.

CONCLUSION

The Board finds that the medical evidence does not establish more than an eight percent permanent upper extremity impairment to each arm.

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[12] Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(c) (March 1995) (to support a schedule award, the attending physician must include a detailed description of the impairment).

[13] A.M.A., *Guides* 449, Table 15-23. A grade modifier 3 is for axon loss, constant symptoms and atrophy or weakness.

[14] The table indicates that an impairment of nine percent could be found, although this would apparently only occur if the functional scale was beyond severe. No evidence supporting a modification to nine percent was submitted.

[15] *Albert Valverde*, 36 ECAB 233, 237 (1984).

[16] 20 C.F.R. § 501.2(c).

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated February 18, 2010 is affirmed.

Issued: February 2, 2011
Washington, DC

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board